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DIVISION OF HEALTH CARE
FINANCIAL POLICY
2009 FEB 12 P 3:31
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Comments submitted to the Special Commission on the Health Care Payment System
By Carol Pryor, Policy Director, The Access Project
February 11, 2009

Thank you for the opportunity to provide input to the Special Commission on Health Care Payment System.

I am the Policy Director at The Access Project, a national health care access research and advocacy organization. My organization has worked on the issue of medical debt and the financial and access consequences of unaffordable care for almost ten years; we have published numerous research studies on these issues and work directly with clients with medical debt to help them resolve unaffordable medical bills.

The Commission states that its mission is to evaluate the health care payment system and recommend reforms to be used by *all* payers to provide incentives for cost-effective and patient-centered care, including innovative methods such as episode-based payments, global payments, tiering of providers, and blended capitation rates.

This work is clearly of vital importance, considering the exorbitant costs of our current health care system combined with inefficient and often ineffective results. In reviewing this system, however, it is important to remember that payers include not only private and public insurers, but also consumers. Insured consumers pay for care through premiums, deductibles, co-payments, and co-insurance. The uninsured are often billed full charges for their care, without even the discounts that insurers are able to secure. In 2007, consumers paid \$269 billion out-of-pocket for health care (excluding premiums), or 14% of national health care expenditures.¹

These costs are becoming unsustainable for American families. In 2007, 41 percent of working-age adults in the United States reported problems paying their medical bills or accrued medical debt. Underinsured adults or those with gaps in their health insurance reported the highest rates of medical bill problems.² Research has also shown that the increase in the proportion of Americans reporting problems paying medical bills was the primary reason for an increase in insured people delaying or going without needed medical care in recent years.³

A wide body of evidence now exists documenting that out-of-pocket costs for care are increasing at rates much faster than family incomes,⁴ that the uninsured and those with inadequate insurance are more likely to delay or forgo needed care,⁵ and that the uninsured and those faced with cost barriers to care experience worse health outcomes

than those with adequate coverage. In order to provide cost-effective and patient-centered care – which implies access to needed care in a timely fashion – the ways in which patients are required to pay for their care must also be reformed.

While overwhelming expenses resulting from catastrophic medical incidents are one reason for medical debt and unaffordable care, research shows that even relatively modest levels of out-of-pocket spending can create affordability problems. In 2007, about 40 percent of people with medical bill problems had out-of-pocket expenditures of \$500 or less, and 59% had expenditures of \$1,000 or less. This was especially true for families with lower-incomes and/or those with family members with chronic illnesses.

For these families, even relatively low out-of-pocket spending, measured as a percentage of income, could cause affordability problems. About one-third of families with incomes below 200 percent of the Federal Poverty Level (FPL) reported medical bill problems at the lowest levels of out-of-pocket spending – less than 2.5 percent of family income -- compared to 16.2 percent of those with moderate incomes (200-400% FPL), and eight percent of those with higher incomes (over 400% FPL). Similarly 19 percent of those with one or more chronic conditions experienced medical bill problems when spending 2.5 percent or less of their income on health care, compared to 13 percent of those with no chronic conditions. Nearly two-thirds of those with one or more chronic conditions who spent 5 to 7.5 percent of their income on out-of-pocket spending experienced medical bill problems, compared to 43 percent of those with no chronic conditions.⁶

One proposed solution to the problem of ever-increasing health care costs has been *increasing* families' out-of-pocket expenses, often through the creation of tax-exempt health savings accounts attached to high deductible health insurance policies. The theory behind these proposals is that high health care costs are the result of unnecessary consumer spending on health care. While some employers, desperate for ways to restrain premium costs, have bought these policies, there is little evidence that they actually lower overall health care costs. According to one report, increasing cost sharing in relation to a consumer's resources results either in serious financial strain or reduced access to care. Moreover, since a relatively small percentage of the population accounts for most medical spending, a large portion of this spending exceeds patients' out-of-pocket liabilities, even in high deductible plans.⁷ Another study found that employers who shifted too much of the cost of drugs to their workers could end up increasing rather than decreasing spending, through absenteeism and lost productivity.⁸ And yet another study found that children with inadequate insurance were more likely to skip recommended vaccinations – a clearly beneficial preventative treatment -- than children with health insurance that fully covered these costs.⁹

Some employers have *reduced* cost sharing for clearly beneficial treatment regimens, most commonly for certain chronic conditions. Pitney Bowes, for example, reduced coinsurance for drugs used to treat three chronic conditions (diabetes, asthma, and hypertension) to the lowest cost-sharing tier (10% coinsurance rather than 20% or 50%). The company saw both reduced direct medical costs (such as emergency room visits and hospitalizations) and indirect costs (reduced sick-leave and disability costs).¹⁰ Another approach some employers have experimented with involves varying health plan

premiums and cost sharing based on employees' incomes, in order to reduce the financial burden on employees with fewer resources available to pay for health care.¹¹

These comments are not designed to prescribe particular benefit design packages or cost-sharing approaches. However, I believe it is essential that the issue of consumer cost-sharing and premium payments is included in the Commission's mission, and that the Commission research innovations in consumer cost-sharing and payments as well as payments from insurers. Unaffordable care results in delayed care, which then often results in the need for more expensive treatment down the line. I strongly urge that you consider the issue of appropriate consumer, as well as provider, incentives in developing payment approaches designed to ensure that people get patient-centered, cost-effective, quality care in a reformed health care system.

¹ *National Health Care Expenditures, Table 6, Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2007*, Centers for Medicare and Medicaid Services.

(http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp#TopOfPage)

² S. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families*, The Commonwealth Fund, August 2008.

³ P. Cunningham, *Trade-offs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007*, Tracking Report No. 21, Center for Studying Health System Change, September 2008.

⁴ Banthin, J. et al., "Financial Burden of Health Care, 2001-2004," *Health Affairs*, Vol. 27, No. 1, January/February 2008.

⁵ Cunningham, P. *Trade-offs Getting Tougher*, op.cit.

⁶ P. Cunningham et al., *Living on the Edge: Health Care Expenses Strain Family Budgets*, Research Brief No. 10, Center for Studying Health System Change, December 2008.

⁷ H.T. Tu and P.B. Ginsburg, *Benefit Design Innovations: Implications for Consumer-Directed Health Care*, Issue Brief No. 109, Center for Studying Health System Change, February 2007.

⁸ M. Freudenheim, "Skimping on Drug Benefits Doesn't Pay," *New York Times*, June 27, 2007.

⁹ A. Manning, "Kids Without Enough Insurance Skip Vaccines," *USA Today*, August 8, 2007.

¹⁰ *Benefit Design Innovations*, op.cit.

¹¹ *Ibid.*